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SURGICAL LECTURES.

Theatre, St. Thomas's Hospital,
THURSDAY EVENING,
MAY 20, 1824.

LECTURE 68.

Scrofula.

I shall now proceed to speak of diseases of the hip-joint, psoas and lumber abscess, and vertebral diseases.

Diseases of the Hip-Joint.

Diseases of the hip-joint are more liable to be mistaken than scrofulous diseases of any other part of the body; much error prevails with respect to them.—The first circumstance which indicates disease of the hip-joint, is some degree of lameness, and pain in the knee. The motions of the joint are impeded; extension is performed with difficulty; the child's knee is bent, and the heel on the diseased side scarcely rests upon the ground. Besides this incapacity for extension, great difficulty is experienced in the flexion of the joint. Thus, if you attempt to bend the knee towards the abdomen, the child shrinks from the touch and complains of pain. If you throw something on the floor, and desire the child to pick it up, you will observe that in attempting to get possession of it, the child bends only the sound knee. If you say, "let me see you put your foot on the chair;" the child does this readily enough with the sound leg, but is incapable of doing it with the other, in consequence of the confined state of the flexion of the joint. The rotation of the joint is also impeded; more especially the rotation inwards, which cannot be attempted without great pain and uneasiness. There is apparently a difference in the length of the limb: the unsound limb at first appears longer than the other.—It is possible that an effusion into the head of the joint may push down the limb a little, but I doubt whether this has any influence in producing an elongated appearance of the limb. The length of the limb is not really

increased, but an appearance of elongation is produced by the parietes being depressed on the diseased side; if you draw a line from the spinous process of the ilium from one side to the other, you will find the difference of an inch. After a short time, indeed, a considerable reduction takes place in the length of the limb, the reason for which you will immediately see.

When you endeavour to ascertain whether disease of the hip-joint exists or not, you should first place the patient on his back, and examine whether the sides of the pelvis are equal; the pelvis will be lower on the diseased side. Having placed the patient in the recumbent posture, you will then bend the knee towards the abdomen, which, if there be disease of the hip-joint, will occasion considerable pain. In rotating the joint also, much pain will be excited in consequence of its stiffened state. You will then turn the patient on his face, and observe whether the nates are lower on one side than on the other: there is generally a difference of an inch or more on the diseased side. These are the common characters of this disease. On dissection you find the following circumstances: in the first place a quantity of adhesive matter is poured out about the joint; the ligaments are much thickened; the synovial surface is inflamed, and often slightly ulcerated; the cartilages of the joint are ulcerated; and, lastly, the bone itself is sometimes absorbed, not only the head of the bone which enters the acetabulum, but the acetabulum itself. You will find examples of all these appearances in the preparations on the table; there is one in which the head of the bone has been absorbed from ulceration, and another in which the cavity of the acetabulum has undergone a remarkable alteration, the upper part of it having been absorbed.—Abscesses are frequently formed in diseases of the hip-joint, which take different directions; in general their course is down the thigh, between the trochanters, and the outer surface of the thigh, where they break. Sometimes they occur in the upper part of the thigh; there is an example in the Collection, in which an abscess occurred in the direction of the femoral artery, and, by its pressure, occasioned the absorption of a

considerable portion of the vessel itself. Sometimes the abscess breaks into the rectum; there is an example of this in a preparation on the table, where you will perceive the rectum very considerably enlarged, at the place into which the abscess has broken. Abscesses sometimes take their course into the vagina, from whence the matter is discharged; an instance of this kind occurred recently in a child of eleven years of age: it will be right, therefore, to mention to the friends of the patient that there is great variety as to the course which abscesses take in this disease.

The cause of this disease is in general too much exertion; too long a walk, for instance, for the strength of the patient, which produces inflammation of the synovial surface.

Treatment of diseases of the Hip-joint.

With respect to the treatment of this disease, you will observe, during the inflammatory stages, the same plan which I have recommended to you in the treatment of scrofulous complaints. It may be observed, generally, that if you do not cure a case of diseased hip-joint in a few weeks, from six to ten weeks for instance, you will not succeed at all. In the first place the recumbent posture, and as much rest as possible, should be strictly enjoined. If there is much pain, leech should be applied; evaporating lotions should also be employed in the first few days. If you do not find the inflammation yield in a few days, it will be right to put a large blister over the part, and to keep it open with the unguentum sabinæ for a considerable length of time. The surface kept open with the savine ointment, should not exceed the size of a crown piece, as you might otherwise produce too much irritation, and do more harm than good. Issues and setons are more applied here than in other diseases of the joints. It is better to regulate the degree of irritation in this way, than to endeavour to produce effects by violent means, which, by exciting fever, might only be adding fuel to the flame. With respect to the treatment of abscesses, it is right in all diseases of joints, and especially in diseases of the hip-joint to postpone the opening of them as long

as you can; unless the abscess is exceedingly large, it is best not to open it at all. The reason for this is, that if you open the abscess early, you expose the cavity of the joint to irritation, whereas, if you delay the opening of it, you suffer the abscess to make its passage to a considerable distance from the joint, so that the opening of it will not be liable to excite much irritation in the cavity of the joint.—The irritation will be very slight if you delay the opening, but if you make it early, the effect will be just the same as if you were to make an incision into the joint. Give time for nature to perform her task, and to fill the joint itself with adhesive matter, as the abscess extends down the limb to a great distance from the joint. I have made up my mind most decidedly on this point, having again and again had an opportunity of contrasting both modes of practice. When the disease is protracted, it would be cruel and injurious to the child to keep it in a state of perfect rest, and it should therefore be allowed to use a crutch. This will prevent the derangement of the general health, and that depression of mind, which arise from long confinement. If the disease has continued for any length of time it is not to be expected but that some lameness will remain.

Of Vertebral Diseases.

A disease similar to the disease in the joints occasionally occurs in the spine, sometimes beginning in the vertebral substance, sometimes in the bone itself. The disease of the vertebral substance has been accurately described by Mr. Pott, and I recommend you to consult his pamphlet, which contains a very admirable history of this disease. It is manifested in the following manner. The child complains of a fixed pain in the spine; the pain, however, is not confined to the spine, but it extends down on each side, in the direction of the nerves arising from the spinal marrow. There are weakness and pain in the back; pain on the sides, more on one side than on the other; and the nerves arising from the spinal marrow are inflamed in consequence of the pressure of the membrane of the spinal marrow. After a little time there is a projection of the spine backwards, one, two or three of the spinous processes projecting more than the others. It usually happens that the lower extremities become affect-

ed; sensibility is diminished, and the muscles lose a portion of their voluntary power. Thus a child affected with this disease is in the constant habit of falling in consequence of a want of due power in the muscles. There is this difference between paralysis and the effect on the lower extremities from this disease, that in the former case all action of the muscles is suspended; in the latter there is diminished power and spasmodic contraction of the muscles. The patient sits with his limbs drawn under him, and his heels towards the nates; and there are, besides, spasmodic twitchings of the limbs. If the lumbar, or dorsal vertebræ, be affected, there will be difficulty in discharging the urine, and the fæces will at length pass off involuntarily.—When the disease is in the neck, the head is the only part of the body, except the vital organs, which retains its power; volition is lost in all the parts of the body below the seat of the disease, and the patient is reduced to the most abject state of helplessness. This disease of the spine is very apt to produce abscesses, in the form of psoas and lumbar abscesses. These abscesses frequently occasion a very considerable loss of substance, as you will have an opportunity of observing, in the preparations which I shall send round. On dissection, the vertebræ are found to be sometimes wholly, and sometimes in part, absorbed; occasionally, four, five, or more vertebræ are absorbed; there is a specimen in the College, in which four vertebræ are wholly, and two are partially, absorbed. This absorption is the effect of pressure on the spinal canal. A curious change takes place, after a time, in the spinal canal, which is, that instead of being smaller, it is larger opposite the part in which the vertebræ have given way. In cases where a cure has been effected, the spinal canal is larger opposite the part where the vertebræ have been absorbed, than it is above or below the diseased part.—The mode in which the disease becomes cured, is by the upper portions of the vertebræ falling on the lower, and in this way anchylosing. This is not matter of conjecture; there are three specimens on the table, in which you will see the upper part of the spine bent forwards so as to meet the lower vertebræ, and in this way pro-

ducing anchylosis. This must be your object in the treatment of this disease. You should keep the spine of the child as much as possible at rest; with this view the child should be kept as steadily as possible in the recumbent posture, so that the vertebræ may be suffered to fall into contact, and by coalescing effect anchylosis. If you attempt to keep the spine straight, you will defeat the object of nature; do not keep the patient in a directly straight line, but rather assist nature in producing the union of the vertebræ. Great attention should be paid to the general health of the child; it should have the best of nourishment, taking care to avoid any thing which may produce feverish excitement; likewise airings in a carriage, care being taken that the body should not be shaken. If the child cannot be kept at rest, if the parents are unable, or refuse to observe these instructions, the next best treatment will be to apply one of Callow's backs, which is worn upon the spine, and fixed round the pelvis and shoulders. As to avoiding deformity, that is out of the question; in all these cases deformity is inevitable; whatever you do this cannot be prevented. The words which now fall from my lips, you may recollect at some future period, when you may be called to a case of this kind; and I now tell you, that I have never met with an example in which the spine, under these circumstances, has been exactly restored to its natural state. All that you can do is to assist, or rather not to oppose the process of nature in producing anchylosis. Blisters, setons, and issues are commonly employed, but they frequently do more harm than good, by the irritation which they excite in the constitution; the means on which you should chiefly rely are rest and the recumbent posture. The part of the spine affected is of no importance with respect to the cure; whether it be the neck, back, or loins, there will be no difference as to the treatment, except in the form of the mechanical means which may be employed.

The next diseases to which I shall call your attention, are

Psoas and Lumbar Abscesses.

With respect to these diseases, I shall point out to you the nature of their treatment very shortly. Disease of the liga-

ments of the spine, commences between the ligaments and the surface of the intervertebral substance. It is very often nothing more than an abscess, from the disease which I have just spoken of, having its origin in inflammation of the spine, and the intervertebral substance. The matter spreads till it reaches the origin of the psoas muscle, which passes into ulceration, and forms a bag, surrounded by a complete ring. The abscess proceeds as far as the tendon of the muscle, by Poupart's ligament, and its further progress is restrained by the tendon; when it passes under Poupart's ligament, between the femoral vein and the symphysis pubis, it has generally attained considerable magnitude, and has the appearance of femoral hernia. You may know this abscess by the following marks: in the first place, when you ask the patient whether he has for a long time had continued pains in the loins; if he has psoas abscess, he will reply, "Yes, four, five, or six months;" you will find that he has a difficulty in extending the thigh; if he puts his legs together, he feels pain and tightness in the groin, and he has increased pain in attempting to exert the limb, in consequence of the psoas muscle being then on the stretch. An excellent case of psoas abscess, in which the symptoms were particularly well marked, occurred in the other hospital a few days ago. This disease has the same seat as femoral hernia, and is, therefore, liable to be confounded with it: the marks which chiefly distinguish it from femoral hernia are the pain in the loins, and the great constitutional disturbance which the patient suffers in the progress of the disease. If the abscess forms on the side of the vertebræ, instead of the fore part, it is termed lumbar abscess, instead of psoas. So much for the nature of psoas and lumbar abscess: with respect to the treatment, you must allow the abscess to take its course; very little can be done in this disease, until it has acquired considerable magnitude. The use of issues is sometimes recommended in these cases. Little can be done, however, to prevent its progress when it is once formed, and I do not know that any advantage is to be derived from counter-irritation. *Digitalis* has been given, with a view of

promoting absorption, but I have not known it in any instance succeed. Mr. CLINE, senior, once gave it, to a very considerable extent, to a boy fourteen or fifteen years old; the abscess diminished for a little time, but when the digitalis was given up, in consequence of its influence on the general health, the disease returned. Let the abscess proceed, until you observe a redness or blush of the skin, and then adopt Mr. ABERNETHY'S plan of making a valvular opening into the part, so as to discharge the matter, and close the wound almost immediately. The danger does not arise from the quantity of matter accumulated, but from the irritation produced by the attempts of nature to close the abscess, and fill the cavity by the process of adhesion. Four days after the abscess is opened, violent symptoms of constitutional irritation are apt to come on, such as great depression of strength, loss of appetite; and the patient is soon reduced to the lowest extremity. It is extremely desirable to prevent the occurrence of these symptoms; and the plan of Mr. ABERNETHY is the best that has ever been suggested by any surgeon, with a view of preventing them.—You are to make the opening obliquely, apply a bandage which is fastened round the abdomen, and endeavour to bring the sides of the abscess as close together as possible, in order to promote the process of adhesion. If ulceration should take place, the matter will be in this way discharged, and all you can do is to support the efforts of nature. I have frequently seen patients recover from this disease. I advise you to use all the means which I recommended in the first Lecture on Scrofula, for the purpose of improving the general health of the patient. A considerable degree of rest should be enjoined; all exercise is injurious in this disease.—Blisters are sometimes placed on the spine, and issues opposite the seat of the disease, but I am not sure that external irritation is of any considerable advantage. I have, however, seen benefit from injecting the abscess; the injection usually employed is the *sulphate of zinc*, or *alumen*. It promotes the adhesive process in the interior of the abscess, glues its sides together, and lessens the purulent secretion.

Rachitis.

I shall conclude this Lecture with a few observations on the disease produced by debility of the vascular system, which is commonly called rickets. It first manifests itself in disease of the mesenteric glands; the abdomen is increased in size, the head is considerably enlarged, and out of proportion to the rest of the body, so that the disease is often mistaken for hydrocephalus. This arises from the softened state of the bones, which are incapable of supporting the action of the arteries in the brain, and the head and forehead are consequently expanded. The chin is expanded, the sides of the jaw are brought together, and the whole of the features are altered, so that in general, by merely looking at the face of a patient, you may infer from it the state of the spine, and other parts of the body. An alteration takes place in the form of the spine, which has a double curvature, above and below, like the Italic *S*. Nature endeavours still to preserve the perpendicular line of the body, by producing a second curvature as soon as one begins, and the equilibrium is maintained, though there is a considerable variation in the form of the spine. The scapula is also considerably projected; a parent will come to you, and say, "I am very uneasy about my child's shoulder—it is growing out." You will judge from this alteration in the shoulder, that there is some alteration in the form of the spine and ribs. Pressure on the shoulder, therefore, with a view of remedying this defect, is a most absurd and unscientific practice; it may give pain, but can do no possible good. The spine in these cases has given way in two directions, and the ribs on one side are more curved than on the other. This incurvation of the ribs, occasions the alteration in the form of the scapula. The anterior part of the chest is extremely projected; the sternum is sometimes sunk in between the cartilages of the ribs, and sometimes advances so as to form what is called a chicken breast. The os humeri, the radius and ulna, the femur, and the tibia, all undergo an additional curvature. Absorption of some of the bones at length takes place, and nothing but the cartilage remains. When you feel the os humeri of a child under this disease, it seems as if it had had a fall, and the bone had

been fractured; the ossific matter is absorbed, and nothing but cartilage remains. The same appearance is frequently observed in the femur, and knee joints of children, in the low alleys of this town, who are deprived of healthy or proper nourishment, and get scarcely any thing, perhaps, but a little gin, which their mothers give them by way of comfort, though they give them nothing to eat. These are the miserable changes to which rickety patients are subject. The cause of all this is a great deficiency in the powers of the circulation, in consequence of which the bones lose their phosphate of lime, and become spongy at the extremities, and the joints therefore are exceedingly enlarged. The ossific matter binds down the cartilages, so as to prevent their expansion; hence arises a diminution of the ossific deposit, which leads to the alteration in the form of the bones. With respect to the treatment of these cases, you will observe the same general principles which I laid down in the first lecture on scrofula, and you will also resort to mechanical means. For the enlargement of the head, it will be right to use some sort of pressure; a cap or a roller round the head may be worn, for the purpose of preventing the growth of the head by the pressure of the arteries of the brain. The next point is to prevent the curvature of the spine, and for that purpose it has been the practice to keep children in the recumbent posture for a great length of time. This is a plan which I by no means advise; exercise is absolutely necessary to the health of children, and I am glad to find that a respectable gentleman at the West end of the town, as well as a gentleman at Bath, have adopted more rational principles in the treatment of this disease. The cause of this disease is debility, and deficiency in the circulation: how is it possible then to give vigour to the circulation, if the child is kept in a confined atmosphere, and prevented from taking exercise, and participating in those amusements which are so essential to health? Exercise should be freely allowed, taking care only that it be not protracted so as to occasion fatigue. How, it may be asked, can you allow exercise, and at the same time bring the spine into a straight position? By giving artificial support to the spine. This may be effected by two springs of

steel, added to stays, one on each side of the spine, which may be worn by the patient in any position. CALLOW's back is a good mechanical contrivance; it fits to the back of the patient, and is passed round the pelvis without pressing on the sides; the pressure is on the crista of the ilium, and not on the sides. In the use of mechanical means, the great object should be not to force the child into a constrained position, but merely to prevent inclination on one side or the other. I have known children laid down for a length of time, to the great injury of their general health, without producing any effect on the distortion. A lady of great talent and great resolution, lay for twelve months in the recumbent posture, and rose with her spine in the same state, but with an additional disease in the bladder. The urine was loaded with an immense quantity of mucus, her natural delicacy having restrained her from making water as often as she had occasion. This was followed by a disease of the womb, which proved fatal. I have read a book lately with great pleasure, or rather I have looked through it, for I cannot say that I very often read a book, in which the author recommends a particular mode of exercise, with a view of bringing certain muscles of the body into action, so as to oppose resistance where there is any deviation from the natural form. The plan is founded on sound and rational principles, and is well calculated to have the effect of opening the chest, keeping the shoulders well back, and bringing the spine into its natural position. In rickety affections of the knees, horse exercise is of great advantage; if the patient is very young, he may be allowed to ride the rocking-horse as long as he likes. The position on horseback throws the knees outwards, while the exercise is beneficial to the general health of the patient.

I shall detain you, Gentlemen, a few moments longer on my own affairs and those of my colleagues. Their feelings have been hurt by the observations which I made on the abuse of mercury in the treatment of patients for gonorrhœa in these hospitals. Those observations having been made for many years in these lectures, are not applicable to them. Who are the men, gentlemen, against whom it has been supposed that these

observations were directed?—Are they men whom I could possibly feel disposed to injure? Mr. TRAVERS was my apprentice, Mr. GREEN is my godson, Mr. TYRRELL is my nephew, Mr. KEY is my nephew, Mr. MORGAN was my apprentice. I feel proud in having such men around me, and I believe at no former period has the surgical department of these hospitals been so well filled as it is by them. I do not wish to be understood as disparaging the abilities of former surgeons, but what I do say is, that there have never at any one time, been so many persons officiating as surgeons to these hospitals, who have been so properly educated to the profession. It is my wish to uphold the profession, and it is because I wish to uphold it, that I wish its abuses to be corrected. I believe much good has already resulted from my observations on the abuse of mercury. It is not my intention to retract my opinions, and I am happy in being able to state that the present surgeons of St. Thomas's and Guy's have never pursued the system of treatment which I deprecated in the Lecture on Gonorrhœa, and that the venereal wards of Guy's are about to be opened within a week *under new and improved regulations!* I have spoken to the gentleman who rules over that hospital, and I have the satisfaction of stating that making patients spit three half pints a day will no longer be a part of the system, but that the Venereal wards will be within a week opened *under new and improved auspices.* I trust that harmony and unanimity will ever be preserved among the Members of the Profession, which are essential for their mutual advantage, and the advantage of the public, and it shall not be my fault, if that harmony is ever disturbed.*

* After this Lecture, Sir A. COOPER, for reasons which we shall leave the 'Hole and Corner' surgeons to account for, abruptly discontinued delivering his lectures at *St. Thomas's* Hospital; the ensuing lectures on Fractures, were delivered in the operating theatre of Guy's Hospital. The Lecture on Gonorrhœa, which contained Sir ASTLEY'S manly and indignant remarks on the "infamous practice" of salivating patients for that complaint, which prevailed in the Borough Hospitals was delivered on the 18th of April. These remarks had been made year after year by the Learned Professor, but they were unpublished, and the abuse remained uncorrected. The Lecture was *published* in THE LANCET on the 15th of May, and on the 20th of May, Sir ASTLEY announced that the venereal wards at Guy's would be opened within a week under new and improved regulations. That the profession and the public may judge of the nature of the abuse, of which the publicity given to it in THE LANCET effected an immediate correction, we will subjoin in this place some of Sir ASTLEY'S observations in the Lecture on Gonorrhœa:—

'Look, gentlemen, at 100 patients in our foul wards, many of whom come into the Hospital with syphilis and gonorrhœa, and many, I am sorry to say, who have only gonorrhœa, but who are invariably carried to these wards. What is the miserable treatment of these patients? You are aware, gentlemen, that I scarcely ever enter the foul wards of the other hospital; when a particular case demands my attention I have the patient removed to a clean ward. I will tell you why I do not enter these wards, gentlemen. I abstain from entering them, because patients under gonorrhœa are compelled to undergo so infamous a system of treatment that I cannot bear to witness it. To compel an unfortunate patient to undergo a course of mercury for a disease which does not require it, is a proceeding which reflects disgrace and dishonour on the character of a medical institution. No consideration shall induce me to repress my feelings on this subject—no authority shall restrain me from giving full

CHEMISTRY.

The Electrometer is an indispensable instrument for the successful study of the laws of electricity, and should be provided by every one who is desirous of prosecuting the science with any satisfaction; in fact without this instrument, and a considerable degree of personal experiment with it, no one, strictly speaking, can know any thing about electricity; he may become acquainted, it is true, with a "general knowledge" of electricity from books, or from attending Lectures on the subject; but as "general knowledge" commonly means "general ignorance" we would not advise any one of our readers to acquire such proficiency. If he is not enabled to obtain an expensive electrometer, we would advise him to practice with some simple contrivance as a substitute: viz. let him suspend two light balls made of the pith of elder within a dry 8 oz. phial, by fine threads of cotton attached to the eye of a common coat button, which must be made to cover and rest on the mouth of the bottle. With this contrivance he may experiment with advantage, and be enabled to detect very small changes of electrical action.—We would advise him to rub every substance likely to shew electricity with a silk handkerchief, and present it, after it has been rubbed, to the metallic button on the mouth of the phial; which we will call the cap of the electrometer. By this means he will witness the various effects produced by friction on different substances, and will be enabled to judge correctly of certain laws and phenomena, too minute to be described in books or developed in public lectures; but at the same time too important to be neglected. If a piece of sealing wax be rubbed with flannel and presented to the cap of the electrometer, the balls will diverge; if the flannel be now presented to it, the balls will first close and presently diverge again. Or if the flannel, after excitation, be first presented to the cap of the electrometer, the balls will diverge; but now, when the sealing wax is presented, instead of diverging further, as might be expected from observ-

expression to those feelings. As long as I continue a surgeon of Guy's Hospital, I will endeavour to do my duty, but I care not whether I continue a surgeon of that Hospital another day. I do say that the present treatment of patients under gonorrhœa in these Hospitals, by putting them unnecessarily under a course of mercury for five or six weeks, is infamous and disgraceful. The health of the patient is perhaps irremediably destroyed by this treatment, and after all not the slightest effect is produced by it on the disease. If he is cured of his gonorrhœa at all, he must be cured by other means. If you go to a patient for gonorrhœa in the foul wards at the end of his course, and ask him how many times he has rubbed in, he will generally answer "twenty-eight times." If you ask whether he is salivated, he will tell you that he spits three pints a day, but ask him whether his gonorrhœa is cured, and he will reply "No, I have my clap still upon me." His disease is not in the slightest degree affected by the mercurial course to which he has been so unpardonably subjected, and it will be after all necessary to cure him by injections or other means. When so infamous a practice prevails I cannot satisfy my own feelings by resorting to milk and water language; every man of common feeling and honesty, is bound to speak out on such an occasion.

ing the effect it produced in the last experiment, the balls will collapse. Either excited glass, or sealing wax, will cause a divergance of the pith balls when presented singly, but will cause no effect whatever when presented together: if the sealing wax and flannel, used in the former experiment, be presented at the same time to the cap of the electrometer, no divergance will take place. These experiments are important,—an explanation of the phenomena involve at once the subject of *positive and negative* electricity.

It was at first conceived that these phenomena were peculiar to the substance by which they were produced; and hence the power excited by rubbing glass was called *vitreous* electricity, and that resulting from the friction on sealing wax *resinous* electricity. But it is now demonstrated that *both* powers are produced in every case of electrical excitation, and as their mutual action resembles an affirmative and a negative power, the terms *positive* and *negative* electricity have been substituted for vitreous and resinous. The question, whether these counteracting phenomena, are produced by a plus and minus state of the bodies engaged in excitation, or whether there are two distinct fluids of different properties called into action by friction, at present engage the attention of philosophers, and is far from being determined, either in favour of the first hypothesis, or the last—and, in fact, until we know whether electricity is material, or simply a quality of matter, this question cannot be set at rest.

HOSPITAL REPORTS.

GUY'S HOSPITAL.

Continuation of the Case of W. W. in Lazarus.

July 22. The powerful twitchings of the muscles on the side of the neck continue just as before. He complains of not being able to sleep at night; pulse continues rather quick, and the tongue is furred; he says he cannot perceive any alteration in the violence of the pain.

July 24th. Was yesterday cupped to the extent of fourteen ounces, since which he says he has been a little easier. Pulse 80, but not hard; whilst lying on the pillow he is easy, but the slightest movement of the head or neck brings on the pain and the spasms; he does not complain of being thirsty, and the secretions from the alimentary canal are natural.

July 26th. He complains to-day of having pain also on the left side of the neck, but principally on the right side, shooting down between the shoulders. He labours much to breathe during the violence of the paroxysm; his mouth is twisted in various directions, and his whole trunk drawn towards the right side. A seton has been introduced in the neck, opposite the spinous process of the second cervical vertebra.—His mouth is getting rather sore by the mercury. He continues his former medicine, with an addition of *Opium*, at night.

As the improvement in this case must be very gradual, we

shall notice any favourable change when it occurs, or any alteration that may take place in the treatment. Without one or the other, daily notices would be only so many repetitions, which would be tiresome without affording any information.

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Case of Dropsy of the Lower Extremity, from pressure on the External Iliac Vein.

W. W., aged 40, was admitted into Job's ward, June 30, with a swelling of the right leg. He says that about two years since he was kicked by a horse, whilst at work in the stables at Greenwich; the blow given by one foot of the horse was received just above the crista of the ilium, and the other foot struck the right testicle, which produced great inflammation in it, and soon after the glands in the groin began to swell, and remained very large and hard for a considerable time. He applied leeches and washes to the testicle, which reduced the inflammation, but did not remove it; and about six weeks after an abscess formed, which burst, and discharged, according to the patient's account, a considerable quantity of matter. This kept up the irritation in the gland, and will account for its remaining a long time enlarged. The gland, however, did not suppurate. For the five months preceding his admission, he says the limb was just as large as when he came in. It was then about twice the size of the other leg. The skin had a brawny feel and appearance. —The swelling was rather tense, but yielded to pressure, and immediately that pressure was removed, it recovered its former figure. The patient complained of its feeling very heavy, and of there being a great numbness in the foot. There was also an enlarged absorbent gland, situated just beneath Poupart's ligament and near its insertion into the pubes, in size as large as a pigeon's egg, and very hard. His tongue was moist, his pulse regular, his sleep good, his appetite unimpaired, looked florid, and his general health not at all disturbed.

Sir ASTLEY saw this patient to-day, July 2d, for Mr. MORGAN, who is unwell, and at the side of the bed made the following remarks: "Dropsy, it is said, arises from an increased action of the exhalents, or from a diminished action in the absorbents, and this in a general way is true; but the appearances of the dropsy produced by these causes, are very different. In the one, you have a tense, shining, semi-transparent skin; and if you press your finger on it, you will find it will sink into the swelling, as if you were kneading dough, and that depression will continue some time; but in the other, or that which arises from a mechanical impediment on the trunks of the absorbents, you cannot produce any pitting on pressure, and the skin has the appearance which you now see."—He then ordered: *Hydrargyri Submur.: gr. iss. bis. in die*, and the limb to be washed with the *Unguent. Hydrarg. Camp:* every night. The patient was

also ordered rest and the horizontal posture with a low diet. With this treatment the swelling rapidly decreased in a week, and continued do so, more slowly, for a fortnight. He then left off his mercury, as his mouth had been kept some time very sore, and was ordered some brisk aperient medicine.

July 26th. The leg now is very little larger than the other; he can use it without any inconvenience; and the glandular enlargement has almost entirely subsided. He takes no other medicine but the house physic, every morning, which is necessary to keep his bowels regular. His health continues very good, and we suppose in another week or two he will leave the hospital.

Operations.

The case of *Gangrene of the Foot*, which we gave last week, was operated on to-day (Tuesday) by Sir ASTLEY COOPER. The leg was removed about four inches below the knee—the stump secured with three ligatures.

Sir ASTLEY also removed a large steatomatous tumour, weighing about three pounds and a half, from the fore part of the shoulder of a man. It rested partly on the pectoral muscle, and in part on the upper arm.

The External Iliac Artery, on the left side, was tied to-day by Mr. KEY.

The woman had a large aneurism of the femoral artery very high up, which she said had only existed three months.—Mr. K. made a semicircular incision through the integuments, of about three inches in length, above Poupart's ligament; and the centre of the curve was just opposite the internal ring. A small vessel, a branch of the external pudic, was now taken up with the tenaculum, and secured; the surface being wiped clean, Mr. K. exposed, with very little additional dissection, the tendon of the external oblique. This was divided in the same direction as the first incision, and the knife was then laid aside, and the finger passed through the internal ring upon the artery, which, with the assistance of a director, was separated sufficiently from its attachments to pass the aneurismal needle, with the ligature under it. The ligature was passed under the vessel in ten minutes, and the patient was removed from the table in fifteen. The pulsation in the tumour immediately ceased. We have never seen Mr. KEY operate with more composure and confidence than in the present instance.

The Theatre was filled with pupils, as much so as at any period of the winter season; and we were much pleased to hear, before we went into it, that the regulations so long painted on the board in the theatre, but so little attended to, were this day to be enforced. Accordingly, we saw the dressers of the operating surgeon place themselves within the bar, and the dressers of the other surgeons very modestly place themselves without; there were some Physicians, and other strangers present, and they

were placed on the one side of the bar, so as not to intercept the view from the body of the theatre; the dressers occupied the front boxes. By this arrangement every individual in the theatre had an opportunity of observing every step of the operation, and approbation was marked on every countenance. — This, however, did not last long, for when Mr. KEY's dressers went to the table, the other dressers forgot to leave it; one intrusion encouraged another, and all was again confusion and uproar.— The old cry of "*Heads! heads!*" and the new one of "*Regulations! Regulations!*" became general, and all were grumbling and some were growling. We could certainly name some dressers' heads who first broke the order of the day, in being very much out of their places; and if we find that they repeat the grievance, we shall give them at full length.

We really think that one word from the Surgeon would have restored the arrangement intended, if he had noticed the first intrusion; and we hope that as the surgeons of Guy's take the lead in all arrangements conducive to the comfort of the students, that they will not allow this attempt to be rendered abortive by the turbulence of two or three individuals.

The accidents received this week are, a dislocation of the elbow; an injury to the thigh; another to the abdomen; a fractured thigh; an injury to the back, and a fracture of the humerus.

ST. THOMAS'S HOSPITAL.

CLINICAL LECTURE.

July 21.—Mr. TYRRELL, after making a few observations on the case of erysipelas in Abraham, proceeded to speak of the different species of cataract, and the operations required for their removal.

I shall (said Mr. T.) for the sake of an arrangement divide *cataracts* into *lenticular*, *capsular*, *and lenticulo-capsular* or the congenital cataract, and first of the lenticular. During its formation, objects are seen as through a mist or through a gauze, and at this time probably if you look into the eye you will see no opacity of the lens; but in a short time, you may distinguish a speck in the pupil, of a dirty white colour, and this gradually increases in extent and density, and the vision is gradually destroyed. During its progress the patient can see but in a weak light, by which circumstance you may distinguish it from amaurosis, for as the pupil dilates the rays of light pass through that part of the lens which remains transparent, and therefore the patient can distinguish objects better: whereas in amaurosis vision is little influenced by the degree of light. These cataracts are divided from their different densities into the *firm*, *soft* or caseous, and *fluid* cataracts. The firm cataract occurs most frequently at the latter periods of life. The opacity is circumscribed in the centre of the lens, and of a yellowish or amber colour. If you look into the pupil from the side of the eye, there

appears a space between the opaque lens and the iris; and sometimes there is a shadow of the iris thrown upon the lens; and by dilating the pupil with belladonna you can see the transparent margin of the lens. In the soft or caseous cataract, the lens appears of a dense white, like a curdly matter; it is very large, and sometimes increased to twice its natural size, so that it protrudes more than the firm cataract, and on looking into the posterior chamber, you do not see any space between the iris and lens. You may sometimes see spots of a whiter colour in this cataract. The *fluid* cataract is of a milky appearance has at the same time a bluish tint as the light shines in some degree through it. On dilating the pupil, the opacity is found throughout the lens, and it has not a transparent margin like the firm cataract; but there is, however, commonly a firm nucleus, and in the dilated state of the pupil the patient can distinguish between light and darkness. It is also larger than the firm cataract, and has a somewhat flocculent appearance. The *capsular* cataract is commonly produced by blows, or wounds of the eye, penetrating the cornea, and reaching the lens. It occurs more frequently from inflammation than lenticular cataract does. The opacity may be either in the anterior or in the posterior layer of the capsule, or it may be in both. When the anterior layer alone is opaque, the opacity is close by the pupil, and it appears like a nebula, if you look at the eye from the front; but if you take a side view you immediately see that the cornea is clear, and that the opacity is behind the pupil. —When the posterior layer is opaque, you may distinguish it by its depth and the apparent concavity of the lens. Whenever radii are seen in cataracts, BEER has given them as decisive marks of the cataract being capsular. But I have also found them to be lenticular, and to occur in middle aged persons. In its incipient state it is rather difficult to distinguish capsular cataract from *glaucoma*; but it may be known from that disease by observing the reflection of the rays of light. In glaucoma if you let the light fall through the centre of the pupil, you will see a whitish spot in the bottom of the eye; if you turn the eye a little to the right side you will see it then, and the same on the left side; the spot follows the different motions of the eye, according as you turn it either to the right or left side. On the other hand, the capsular cataract will remain stationary, and will always be seen in the same situation however you may vary the position of the eye.—The patient also sees best in a bright day whilst the sun is shining; whereas a person with incipient capsular cataract can see best towards evening, when the pupil is more dilated. If you apply belladonna also to the eye, the sight will be only more confused in a person having glaucoma; whereas in cataract, by dilating the pupil, the vision will be more improved.

Now the different operations for cataract are, that of *solution*, where you admit the aqueous humour upon the lens by lacerating its capsule; *depression*, in which

you remove the lens from the rays of vision by pushing it into the vitreous humour; or *extraction*, in which you remove the lens through a section of the cornea. There has been a fourth operation described by Dr. BOWEN, called *hyalonyxis*, which I think objectionable, on account of the inflammation likely to be caused in its performance. For further particulars respecting this operation, I must refer you to the last number of ANDERSON'S Journal of Foreign Medicine. I would only recommend you to try the three first.

Previous to performing the operation, however, many points are to be considered. Before extraction, particularly, you should apply the belladonna, in order that the pupil may be dilated to its utmost extent. You obtain also a better knowledge of the internal state of the organ by this than by any other method; and in all cases of amaurosis you should apply it. I will mention to you a case which shows the necessity of doing this. A gentleman applied to an oculist* in town for a dimness of vision; he examined the eye very attentively, and told him he had incipient amaurosis. But not being quite satisfied, he went to another who applied belladonna, by which there was a deep-seated circumscribed opacity discovered, which was supposed to be in the capsule; and therefore in all cases in which there is the least doubt, I should advise you to apply belladonna. By it you will also detect the presence of adhesions between the capsule and lens, which were not discernible before, and therefore, the utility of knowing this before operating is evident, as it would form an important objection to the performance of extraction. In addition to becoming acquainted with these circumstances, it will be also necessary to know if the patient be able to distinguish light from darkness sufficiently to tell where the window is placed, to tell if the hand or any other opaque body be placed before the eye, to tell if a candle be in the room, or to know the light of the fire. The motions of the iris should be free before you proceed to the operation of extraction. The cataract too should have formed without pain, or any other symptom denoting previous internal inflammation. The colour of the lens is also of importance to attend to, as if glaucoma be present the lens will have a greenish tint, and this is the best diagnostic mark of it. It has been said that this is not of much consequence, but I have never seen such cases terminate favorably. You should see also that there are no varicose vessels on the globe of the eye, that there is no ophthalmia existing, and that there is no pain in the head. You may, after satisfying your-

* We do not like this term; if Mr. Tyrrell is anxious (as we believe he is) with the other members of the profession, to unite the treatment of the diseases and operations of the eye with the practice of surgery in general, why attempt to preserve an *useless distinction* of *names*. We remember another and more public occasion, on which Mr. T. said, I am *oculist* to the London Eye Infirmary; but his colleague, said, I am *Surgeon* to the London Ophthalmic Infirmary. Why not then say that the gentleman applied to was a *Surgeon*? Or if a Physician, why not say a *Physician*?

selves on these points, proceed to the operation of extraction, which I shall now describe.

The instruments required are the knife and the curette, having one extremity curved and sharp like a needle, and having a little scoop at the other end. The knife which is commonly used is Beer's of Vienna, it is of a triangular figure, and cuts only on its lower edge, from its point backwards. Here is another (showing this and the former to the pupils) which was used by Wenzel, who at one time made annual visits to this country to operate on persons having cataract; it is in shape very much like the spear-pointed lancet, having a cutting edge on each side. (Here Mr. T. showed the curette, and observed, that the scoop part of it was intended to remove any portions of the lens which might remain in the anterior chamber.) Here are also two small knives, having blunt extremities, for the purpose of enlarging the incision of the cornea if necessary; these are convex and concave, but I prefer the one having the cutting edge on its concavity.

Although the operation is most successful if the marks which I have given be present, yet if the eye is not sufficiently prominent, and if the orbit projects much; if the lens is large, and protudes much into the anterior chamber, these would form additional objections to the performance of the operation. The steps of the operation are these:—the upper lid should be elevated, and fixed firmly against the upper edge of the orbit, by an assistant, who should be attentive enough to watch the progress of the incision of the cornea; for as soon as that is completed, he should immediately let the lid drop. You should then, with the fore and middle fingers of your left hand, depress the lower lid a little, and prevent the globe of the eye being turned towards the nose in the way which I recommended when speaking of the removal of foreign bodies from the cornea. Then hold the knife between the fingers and thumb of your right hand, just as you would hold a pen, and put your ring and little fingers on the outer part of the cheek, in such a way, that although they afford a proper support to the hand, they must not prevent your being able to carry the point of the knife straight through the cornea, without shifting the position of the hand; if you allow the knife to recede in the least degree, the aqueous humour escapes, and the iris falls beneath the edge of the knife. You then introduce the knife from the outer part of the cornea, about a line before its junction with the sclerotic, and a little above the middle line of the cornea, giving the point of the knife at first a slight inclination inwards, then carry it gently, and with an equal motion, across the eye towards the inner canthus; bringing the point out rather below than above the transverse diameter of the cornea. Still, however, there is generally a portion of cornea to be divided beneath the edge of the knife, and this should be done with a gentle undulating motion of the knife down-

wards, not making any pressure on the globe. I have seen it divided on the finger, but this is a bad practice; for if the patient should give a sudden twitch of the eye, the finger slips against the globe, and might cause the evacuation of a great part of the vitreous humour. It is better, if you have any difficulty in finishing the section, to do it with the small curved knife, which I prefer to the scissors. You then introduce the curette with the convexity towards the cornea, and when you have got the point opposite the pupil, you turn it inwards, and lacerate freely the capsule of the lens, and then turn the convexity of the curette downwards, and thus carefully withdraw it. You now make pressure, on the upper part of the globe, with the other end of the curette, and as soon as you see the lens moving from its situation, you gradually diminish the pressure and the lens escapes. If you have any prolapsus of the iris, you desire the patient to close his eye as if asleep, and then you rub gently on the lid, and that causes the iris to recover its proper shape; but if after two or three times you find it does not retract, you might then cautiously evacuate a small portion of the vitreous humour, and this will generally succeed.

When I was first elected to the Eye Infirmary, it was the practice there to bleed subsequently to the operation; but this sometimes occasioned fainting; sickness often followed, and by vomiting the vitreous humour was forced out, and the eye lost. Very slight pressure, from any cause, the mere act of sneezing, coughing, or any gentle exertion, will sometimes produce a loss of the substance of the globe. On account of these trifling injuries proving destructive to the organ after extraction, I was led to try what I could do by depression, and this had been also recommended by Hey and Scarpa, and it appears to me that the objections urged against this operation are not valid.

I lately performed an operation for this disease with the needle, by which I lacerated the capsule of the lens as in operating for soft cataract; exposed the lens to the action of the aqueous humour, by which a great part of it was absorbed, and afterwards depressed the firm nucleus.—I have operated on almost all ages between forty-five and seventy-three, and in every case with complete success. Extraction requires great practice, and as much manual dexterity as any operation in surgery, and a person without having seen it frequently done would find it very difficult to perform. On the other hand, a person who has once been shown the needle operation, can easily perform it; and another reason for adopting it would be, the shorter time which it requires in the performance.

When the cataract is soft, of a cheesy consistence, or fluid, you perform another operation, namely, that of *solution*, which I shall now describe. This is sometimes called the needle operation, and there are three needles in general use: The first is, Saunders' needle, which has a cutting edge from the point to the shoulders. Another is that

used by Sir William Adams, which cuts down the sides as well as at the shoulders; and the third is Scarpa's, which is curved a little at its extremity. The small opening made in the globe in this operation is not of sufficient importance to form an objection to it. If you find there is much difficulty in raising the lid, you may use a speculum for the purpose, which is introduced between the tarsus and the upper lid. The operation is performed either anterior to the iris, when it is called chalionixis, or behind it, when it is called the posterior operation. In the anterior operation I prefer Saunders' needle, and it is introduced a little above the place where you introduce the knife; you then pass it on to the opposite side of the pupil with its flat side towards the iris, then turn the sharp edge to the capsule, and draw the needle several times up and down the capsule, so as freely to lacerate it, and then turn the needle and withdraw it. In the posterior operation, I generally use Sir Wm. Adams' needle; it is introduced just as much behind the anterior edge of the sclerotic as in the former operation it was introduced before it. You then carry the needle through the vitreous tumour to the lens, turn the needle freely between the finger and thumb, so as to break up the structure of the lens, and lacerate its anterior capsule. Previous to performing any of these, the belladonna should be applied, and if you should discover any adhesions between the iris and the capsule, you should take this opportunity of detaching them, from all points but one, as the iris will be drawn towards it, and a good pupil be left. The chief advantage of this operation appears to be, that the lens is not disturbed from its situation. You may generally judge of the laceration being sufficient by the iris becoming concave instead of remaining convex, and the aqueous humour becoming somewhat turbid. For the third mode of operating, namely that by *Depression*, I generally use SCARPA's needle. This is introduced through the sclerotic, about a line behind its junction with the cornea, then carried onwards to the lens, and when you have reached the centre of it, turn the curve of the needle downwards and depress the lens with a little jerk downwards and outwards by elevating the handle of the needle. There would be no objection to the performance of extraction, after the anterior operation, provided the nucleus of the lens did not, after a certain time, appear to be acted on by the aqueous humour. The common consequence of each variety of the needle operation, is iritis, which would yield to the treatment necessary for it, whether arising from common causes or from syphilis.—Sometimes after extraction or solution capsular cataract takes place, without being attended with inflammation or pain, and will require an operation for its removal, which is just like that of the posterior operation, which I have just described. You will recollect the case of the boy on whom I operated a week or two ago, who had capsular cataract;

the divided capsule has been retracted by the action of the iris from the use of belladonna, and a very good pupil is now formed.

The *Congenital* cataract is generally capsular, and if the operation be not performed in five or six years, the lens becomes absorbed. It often happens, after this operation, that portions of the capsule remain in the anterior chamber for years, without undergoing any perceptible change. There is a young woman who comes occasionally to the Eye Infirmary who was operated on fifteen years since, and in the anterior chamber you may see the pieces of the capsule. I operated on seven of these cases last year; and in one patient particularly, I wished to see the effect of removing the lens from its situation, and therefore I broke up the opaque matter of the lens in one eye and pushed as much as I could into the anterior chamber, whilst I allowed the lens to remain *in situ* in the other eye. In the first, I was obliged to repeat the operation, and in the other the absorption went on very well, and they both ultimately succeeded. I have, in addition to the numerous cases on which I have operated, repeatedly seen the operation performed by others, and have never observed any injurious consequences attend them. You may lacerate the lens and its capsule very freely, particularly in the young subject. Mr. TYRRELL performed the different operations several times, on the eyes of sheep, to the different parts of the class, and observed at the close of the lecture, that he did not know whether he had been sufficiently explicit; but added, that if any gentleman wished to see any part of the operations repeated, that he should feel most happy in doing so, as it was his wish that the operations on such a delicate and important organ, should be thoroughly understood.*

The subject of cataract will be continued next week.

Continuation of the case of J. H. in Abraham.

We are glad this week to be able to give a successful termination to this case.

July 22.—Strength continues to improve; sleeps comfortably; tongue moist, but still a little furred; was ordered an increase of his porter, so that he now takes *lb.* ii. daily, and *lb.* iij, of milk.

24.—The wound on the foot looks very healthy, and granulations are fast sprouting from it. There has been a collection of matter in the lower part of the thigh, which has been poulticed, and when it had discharged, straps of soap plaster were used to unite the integuments to the parts beneath, by making gentle pressure. He was ordered to continue his former allowance of medicine, but to have the steaks and chops on alternate days.

* It might appear from a letter which we inserted a fortnight ago, that Mr. T. was remunerated for the lectures which he delivers, but this is not the case; they are delivered gratuitously, for the intended benefit of those attending the Hospital practice.

26.—He is now so much improved, that he thinks he could walk into the square; he had been taken out once in the chair and remained a few minutes, but the sun had at that time nearly left that part of the building, and he felt rather chilled by it. Dr. ELLIOTSON and Mr. TYRREL saw him together to-day, and agreed to diminish his quantum of allowance.—His wine and opium were omitted, and he is to continue the quinine every eight hours instead of every four.

The accidents received this week, are, a laceration of the head; an injury to the ancle from a fall; another from a kick; an injury to the head; ditto to the elbow, and another injury to the head.

We observed this week in the surgery, what we have long looked for, and what we intended, in the next week to have noticed the absence of, and that is, a *list* of the *accidents* received during the week, and the names of the wards in which they have been placed. We give the dresser of the week great credit for setting this example, and we hope that the succeeding dressers will continue the practice. It has long been done at Guy's, and it would be much better to see the boards at St. Thomas's surgery exhibit some more useful notices than "Razors to grind," and "Lodgings to let."

The only operation performed here this week was the removal of a tumour from the forehead by Mr. TYRRELL.

MIDDLESEX HOSPITAL.

Case of Dislocation of the Head of the Femur backwards into the Foramen Ischii.

Thomas Willis a healthy man, æt. 35, admitted June 7th. This man, whilst wrestling with an acquaintance, was thrown on the floor with great violence, and dislocated the left thigh bone at the hip, in the manner above-mentioned. The following is a description of his appearance on being brought to the hospital, and placed in bed. He lies on the bed with his body at an angle with his lower extremities, and his hip projecting. He is lying on his right haunch, and on the outside of his right leg and thigh. The left extremity presents a curious appearance. The hip is turned round, the back part of the thigh, the ham, and heel are directed upwards. Looking at the right leg, in conjunction with the left, the former presented a *lateral*, whilst the latter exhibited the *posterior* aspect—the former presented the appearance of a man lying in bed on his right side, whilst the latter would indicate the position to be *pronate*, or with the face downwards; and the relative situation of the two extremities could not, without the greatest torture to the patient, be altered in any material degree; the whole presented a singular distortion, which also prevented an

accurate admeasurement of the comparative lengths of the two extremities, in which, however, they did not appear to differ very materially.

Reduction.—Previous to the operation some *Emetic Tartar* had been exhibited, for the purpose of producing nausea. About 20 ounces of blood had also been taken from the arm. The operation of reduction was then performed without removing the patient from the bed on which he lay. A towel was applied above the knee, and afterwards attached to the pully. A large towel was then placed between the thighs, and a cushion on the perineum. This latter towel passed over the fore and back part of the trunk, and was attached to the iron bedstead, which was prevented from altering its position, or approaching the wall into which the staple for the pullies was fixed, by a log of wood being interposed. An assistant, having the command of the pullies, kept the muscles of the limb for sometime on the full stretch. One of the surgeons marked the relation of the trochanter with the spine of the ilium. Another held the knee and leg, whilst an assistant kept down the trunk and pelvis. The dislocated limb was now drawn in a direction downwards and forwards, and the surgeon, whose fingers were on the trochanter, having announced that the head of the bone had been drawn out of the notch and the limb sufficiently elongated, the other surgeon rotated the limb into its natural position, the extension made by the pullies being at the same time suddenly relaxed,—and by this single and well-concerted effort, the dislocation was reduced. After the operation he was extremely sick, arising most probably from the medicine previously exhibited.

For several days from this period, there was considerable pain and swelling of the integuments of the thigh, more especially of those surrounding the hip joint; these symptoms were relieved by the application of *leeches* and *cold lotion*, and subsequently a *blister* was applied to the joint. There were also at this period great pain and tenderness on pressure, in the course of the sciatic nerve, more especially in the popliteal cavity, and in its course to form the tibial and fibular divisions supplying the leg and foot. To these symptoms a complete loss of sensation and motion of the foot succeeded, which latter, however, by the application of *leeches, blisters, and stimulating liniments*, has been restored to him, and at this period he is in a fair way of regaining the powers of sensation also. *Electricity* and *stimulating liniments*, are the remedies at present employed, and there appears reason to think that these will at no very distant period be found amply successful.—July 20th.

J. B. æt. 27, admitted June 12th, from the country. This man was thrown out of a cart and dislocated the ancle joint. A surgeon in the village made attempts to reduce it, but failing, sent him to the hospital. Upon examination, it was found that the lower end of the tibia was broken and displaced; the

perpendicular ligament appeared also to have given way, and most probably the tendon of the peroneus longus. The astragalus was removed from its proper position, and was found occupying a situation on the outside of the foot immediately before and below the end of the fibula, which latter appeared also to have sustained some injury and the fractured portion of the tibia to have been moved into the space left by the astragalus. All attempts at reduction of the luxation have failed, and indeed it seems to be a case where success can seldom be anticipated. There were considerable inflammation and swelling of the joint for several days, which were subdued by leeches and cold applications. The limb was subsequently bandaged and retained as nearly as possible in the natural position by splints. At first there was great fear of the astragalus forcing itself through the integuments, but at present it appears to be firmly fixed in its novel situation, and the articulation is altogether much better than could have been anticipated.

WESTMINSTER HOSPITAL.

Saturday, July 24. Sir Anthony Carlisle performed the operation of hydrocele upon a man aged thirty.

The trocar was introduced into the tumor, which was on the right side, an inch from the raphe, inclining it inwards and a little upwards; about sixteen ounces of a serous fluid were evacuated; floating in it were a large quantity of very minute particles of a sebaceous substance, having, in the fluid, an appearance similar to the aurum musivum. As the patient objected to it, the scrotum was not injected.

A man aged about sixty was next brought into the operating theatre, who about twelve years ago had suffered the loss of his penis, that organ having sloughed off as far as the pubes, after receiving an accidental bruise. Since that time the urethra had gradually become contracted at its external orifice; and the patient states that he had spent above 400*l.* in ineffectually endeavouring to procure relief, and was at last forced to apply to the hospital.

From the time of his admittance here, attempts to enlarge the urethra had been made, by means of bougies, but without success, although a small catgut one could, with very great difficulty, be introduced. The cicatrix at the mouth of the urethra, was so unyielding as to make it impossible to dilate it, and at last an operation was proposed and consented to, as the only means of giving and procuring an abatement of the suffering, occasioned by the inability to discharge his urine freely.

Mr. LYNN having, after great difficulty, introduced a very small probe, he, with a sharp pointed scalpel, made an incision down upon it through the cicatrix at the mouth of the urethra; and afterwards introduced a bougie which was secured by a piece of string to retain it in its place.

Mr. LYNN also removed a large quantity of fungi from around the anus of a young woman about 22 years of age.

Wednesday, July 28.—Mary Ashton, who was operated on for Hernia, as detailed in our last report, is in a state of rapid convalescence. The omentum which was tied, has sloughed off entirely, and the wound is healing fast by granulations.

The only accidents of importance, at this hospital, since our last report: are, a fractured thigh; and a wound in the knee of a man, across the patella.

ST. GEORGE'S HOSPITAL.

Friday July 23.—Mr. BRODIE amputated the thigh of a man with a diseased knee joint.

The operation was conducted in the usual manner, and four arteries required ligatures. On examination of the joint after the operation, the patella was found to be anchylosed with the os femoris in the trochlea, and caries in the cartilages of the joint had commenced.

Foreign Department.

BIOGRAPHICAL SKETCH OF COTUGNIUS.

This celebrated anatomist was born at Ruvo, on the 29th of December 1736. His father, Michael Cotugnius, was not rich, but he spared nothing in order to give his son a good education. At the age of nine years, COTUGNIUS could speak the Latin tongue with fluency. At the age of eighteen, he contested for the situation of physician to the *Hospital des Incurables*, at Naples, and succeeded in obtaining it. When only twenty years old, the governors of this hospital appointed him to the chair of surgery, which had been once filled by the distinguished MARCUS AURELIUS SEVERIN. In 1761, scarcely twenty-six years of age, COTUGNIUS published his discovery of the aqueducts of the vestibule and cochlea, which are also called the aqueducts of COTUGNIUS, in honour of the anatomist who first discovered them. At this period he also made known to the world that the labyrinth was filled by lymph, and not by air, as anatomists, prior to the time of COTUGNIUS, had always imagined. In this same year (1761) he discovered the naso-palatine nerve. SCARPA discovered this nerve at the same time as COTUGNIUS, or, we believe, rather before him, and therefore the merit of the discovery is generally given to SCARPA; although the investigations of COTUGNIUS were made without his being in the least acquainted with those of the Pavian Professor.

COTUGNIUS will be classed among the most celebrated medical men of Italy; his labours on the ear entitle him to hold the highest rank among anatomists; medicine is indebted to him for a valuable treatise on sciatica; and physics for ideas which may have assisted in the discovery of galvanism; and some of the most distinguished ornaments of the profession in

the South of Europe, owe their success to the benefit they have derived from his instruction.

COTUGNIUS died on the 6th of October 1822, and bequeathed, on his death bed, to the poor of the *Hospice des Incurables*, at Naples, about 100,000 ducats.

ROYAL ACADEMY OF MEDICINE.

Sitting of the 11th of March.

M. BECLARD presented to the Academy, in the name of M. M. DUBOIS and BELLIVIER, a fœtus which had remained seven years in the womb of the mother. It was contained in a bag situated on the left side of the uterus. It appeared to be transformed into a kind of adipose substance, resembling the fat of dead persons.

Sitting of the 25th of March.

M. M. RICHERAND and JULES CLOQUET exhibited one of the patients from the hospital St. Louis, whose inferior extremities could be lengthened or shortened, when the man liked, to the extent of three or four inches.—From several pathologico-anatomical observations, it was judged that this affection arose from a destruction of the heads of the thigh bones, and from erosion of the parietes of the cotyloid cavities. The patient is fifty years of age, walks with extreme difficulty, but without pain. Whilst resting the body on either limb, it becomes shortened, and the trochanter major touches the crista of the ilium; but when, on the contrary, he raises it, it elongates and returns to its natural size. In this same patient there are several exostoses in different parts of the pelvis, and numerous large osseous tumours in the substance of the muscles.

M. M. CULLERIER and MAINGAULT, presented to the Academy, ossifications of the arachnoid membrane; which were taken from the body of an insane person. Besides this osseous matter, some of which extended into the sulci between the convolutions of the brain, there were found in the hemispheres of this organ, cysts or encysted scrofulous abscesses, developed in the cerebral substance. During his life, the patient had always a disagreeable smell in the nose. On this point M. DUBOIS related to the meeting, a case nearly similar, in which a man, who several years before his death had received a fall from a horse, also constantly had disagreeable smells in the nose.

To the Editor of The Lancet.

Sir,—I send you the following singular case of abdominal tumour, which came under my notice a few days ago, for insertion in your valuable publication. I think it necessary to state, that I do this without the knowledge of the physician under whose care the patient was, but I feel confident that he will readily excuse the liberty I have taken.

I am your's, &c.

July 29th, 1824. W. C.

Singular Case of Abdominal Tumour.

William H., æt. 48, labourer

was admitted into George's ward, St. Thomas's Hospital, June 10th, under the care of Dr. ELLIOTSON, with a swelling in the abdomen, and a sense of general weakness. The patient stated, that about ten days before his admission, he was seized with pain and swelling about the navel, together with sickness at the stomach. In a short time the pain entirely left him, but the swelling continued the same. The swelling was, according to the patient's account, of the same size when it first made its appearance, as at any period afterwards; but this was not the case, for it evidently increased in magnitude after he came to the hospital, and particularly during the last three weeks of his existence. His appetite was bad, countenance pale, and body emaciated. The abdomen was very much enlarged; there was a considerable prominence midway between the umbilicus and scrobiculus cordis, the edge of the liver could be distinctly felt, the lower ribs and scrobiculus cordis were pushed forwards, and on the external surface were several veins, which gave the swelling a bluish appearance. No pulsation whatever could be felt in the tumour. The patient experienced so much pain in the loins, from the pressure of the swelling on the lumbar nerves, that he was obliged, in order to get ease, to lie on his knees and elbows. He also complained of great flatulency.

Various remedies were tried, mercury, setons in the neighbourhood of the tumour, &c., but all without any good effect; the man gradually sank, and on the 24th of this month (July) he died; the swelling ten days before his death, having very much increased in size.

Examination of the body.

On the day after his death the body was examined by Dr. ELLIOTSON, in the presence of three or four pupils, when the following appearances were observed. On making a longitudinal incision through the integuments of the abdomen, it was found that they strongly adhered by means of a firm ligamentous substance, to a tumor which existed in that cavity. After the skin was dissected back, a large tumour presented itself to the view, occupying more than the upper half of the abdomen; having for its boundaries superiorly, the diaphragm, to which it adhered, and which it pressed so much upwards that the size of the chest was considerably diminished; laterally the inferior ribs, and inferiorly the intestines. On examining it more carefully, it was found that this swelling was composed of two parts, the left lobe of the liver forming the anterior and most prominent, and a large cyst the inferior and posterior part. The left lobe of the liver was, throughout its whole substance, in a tuberculated state, and had on its anterior surface several prominences, which were soft and fluctuating to the feel, and were found to be distinct cysts containing soft curd-like matter. The left lobe was so much enlarged, that it formed the whole anterior part of the tumour, and forced the right lobe of the liver behind, so that no portion of it could be

seen, until the left lobe was raised. The next part of the tumour was composed of a large cyst formed of thickened peritoneum, covered anteriorly by the posterior surface of the left lobe of the liver, and containing a large quantity of dark coagulated blood, and a little cheesy matter. This cyst was firmly connected to the duodenum inferiorly, and the stomach on the left side. Externally it was of a red and blue colour, being red in some parts and blue in others. On the upper part of its internal surface, there was a deposit of thick coagulable lymph. The tumour was now removed, in order to ascertain its weight and dimensions. The whole mass (comprising the liver and cyst) weighed 16lb and a ½ avoirdupois.* The larger circumference of the tumour measured about 18 inches, the smaller circumference 12. The right lobe of the liver was rather smaller than natural, the external surface uneven, and covered with tubercles, which were in their incipient state. It was of a dark brown colour, and of a firm consistence throughout. The vena cava inferior, and abdominal aorta, were carefully traced: the vena cava was not compressed, nor was the aorta ruptured in any part of its course. With the exception of the kidneys, spleen, and pancreas, none of the abdominal viscera had preserved their natural colour; the intestines, bladder, and stomach, being of a greenish purple colour. There was a slight effusion of dark coloured fluid into the cavity of the abdomen, and at the upper part of the left lobe of the liver, there was some coagulated blood, which was surrounding one of the cysts that had given way. The peritoneum all over was as diversified in its colour as the intestines.

The chest was very much contracted from the pressure of the tumour; the lungs were healthy, excepting at the lower part, where they adhered to the diaphragm. The heart was small; and on the external surface of the right and left ventricles, there was a kind of gelatinous substance, which on minute examination appeared to be composed of hydatids.

* The dimensions of the tumour were taken at the time of the examination, by means of a piece of string which was afterwards lost; therefore I am obliged to guess the circumference.

To the Editor of The Lancet.

SIR,—In your last number, a student complains, and I doubt not very justly, of the surgeons of one of the hospitals neglecting the fulfilment of their bounden duty, in omitting to communicate to the pupils, whose money they had received, that information which the students had a just right to expect. Now, Sir, this is a complaint which I have too often had cause to make myself; and have heard other pupils do the same. Many a time, have I seen a vigilant young man, all eye and all ear, to get a sight of the different cases, and to catch any observation that a surgeon might make on going from one patient to another through the different wards. But the hurried pace from bed to bed

—the often superficial examination of the patient—and the absence of all comments on the respective cases, however interesting some of them might be, have been such, that the student has come out of the ward just as wise as he went in. I have seen pupils anxiously listening at the bed side for something that might be said, and, in the moment of disappointment, as anxiously enquiring of each other what the case really was, but without being able to gain the slightest satisfactory information. Indeed, it often happens that some of the pupils cannot even get a sight of the patient. But is such a practice on the part of the surgeons just? Ought they to be perfectly indifferent whether the students obtain the information they pay for, or not? Does not every examination at the College imply at least the contrary? What does a young man enter at an Hospital for? Is it to obtain information, or is it merely to walk into the wards and then to walk out again? It is not expected that a surgeon will stop and give a *lecture* over every patient. But why is not some regulation adopted, by which all the students, in succession, may have a *sight* of the patient, and a good view of every local case which happens to be an external and visible one? Why are they not more frequently made acquainted with the name*, and real nature of the disease; its history (so far as it can be collected from the patient), the means adopted for the cure, and the reasons why such remedies are chosen? Why, in short, are not observations of *practical* importance, more commonly made in the presence of the students, for their individual advantage? We should not then hear some of the pupils say, "*There is nothing to be learnt here!*" and others, "*We must catch what we can.*"

Upon the whole, it must be manifest to every reflecting mind, that some sort of reform is wanting; a little more sterling bedside instruction in exchange for that culpable silence and reserve which is now so common. I must not, however, confine my complaints to the surgeons only. I have heard also repeatedly, the same kind of dissatisfaction expressed by Students, in regard to Hospital Physicians, that is, that they bestow little or no pains in giving instruction to their pupils while passing through the wards.

I rely on your impartiality, and am convinced of your desire to assist the medical student in the important acquisition of that knowledge, which is necessary to enable him to practice with credit to himself, and satisfaction to his patients,

I am Sir,
Yours respectfully,
A STUDENT
OF ANOTHER HOSPITAL.

July 23. 1824.

* In SOME Hospitals, the name of the disease is specified on the card affixed to the patients' bed; in OTHERS, not. It ought to be the case in all.

TALIACOTIAN OPERATION.

This operation has been performed three times in Europe within the last twelve months, by Mr. DAVIS and Mr. TRAVERS, in London, and Professor

DELPECH, at Montpellier. We are happy to state that two of these operations were successful, viz. those of Mr. DAVIS and Professor DELPECH.

HYDROPHOBIA.—We regret that in none of the numerous instances of hydrophobia which have lately occurred in this country, has the plan so strenuously recommended by M. MAGENDIE, (injection of water into the veins) been tried. The ordinary remedies, such as blood-letting, opium, &c. so seldom afford any relief in this dreadful disease, that we are surprised that a mode of treatment so simple as M. MAGENDIE'S, and which holds out a chance of cure has not received a fair and impartial trial. From the publicity which M. MAGENDIE'S case received, there can scarcely be a professional man in the country who is not acquainted with it, and we therefore entreat medical men to try the injection of water into the veins in any case of hydrophobia which may come under their notice. Some blood ought to be abstracted from the arm previously to the injection of the water, and the water should be injected in a luke warm state.

LITERARY INTELLIGENCE

In the Press, a treatise on the necessity of attending to the secretions, particularly the *Arguropoietic* Secretion, in all complaints; by JOHN PEARSON, WILLIAM LAWRENCE, and BENJAMIN TRAVERS, Esqs. Surgeons.

NAVAL PROMOTIONS.

A. Courtney and T. Thompson, Isis; George Henry Dabbs (assistant) Jasper; James Veitch (assistant), Robert M'Farlane (acting), Liffey; L. M'Kay, Maidstone; Charles Mortimer (assistant), Martin; H. Brock, and John Robertson (assistant), Meteor; Henry Towsey Niemen; William Pennycook (assistant) Nimrod; Charles Henderson, Orestes, Frederick Crellin (assistant,) Pelorus; James Prior, Perseus receiving ship; James Osmand, Primrose; James Carruthers and William Dickson (assistant,) Pylades; Rowland Griffiths and A. M'Arthur, Ramillies; Archibald Johnson (assistant,) Redwing; T. Dunn (assistant,) Sapho; A. Snall (acting,) Satellite; Benjamin Dickson (acting,) and Alexander Linton (assistant,) Serapis; Isaac Noot and R. Wilson (assistant,) Seringapatam; John Riddell (assistant,) Spartiate; William Anderson, Starling; Thomas Gibson (assistant,) Superb; John Vallence (assistant,) Terror; John Macintyre and William Marshall, Victory; F. M'B. Chevers, and Alexander Baird and William Peatie (assistant,) Wellesley.

MARRIED.

On the 29th inst. at Camberwell, Mr John Browne, Surgeon of that place' to Sarah Anne, eldest daughter of the late Richard Cookes, Esq. of Rush Hill.

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